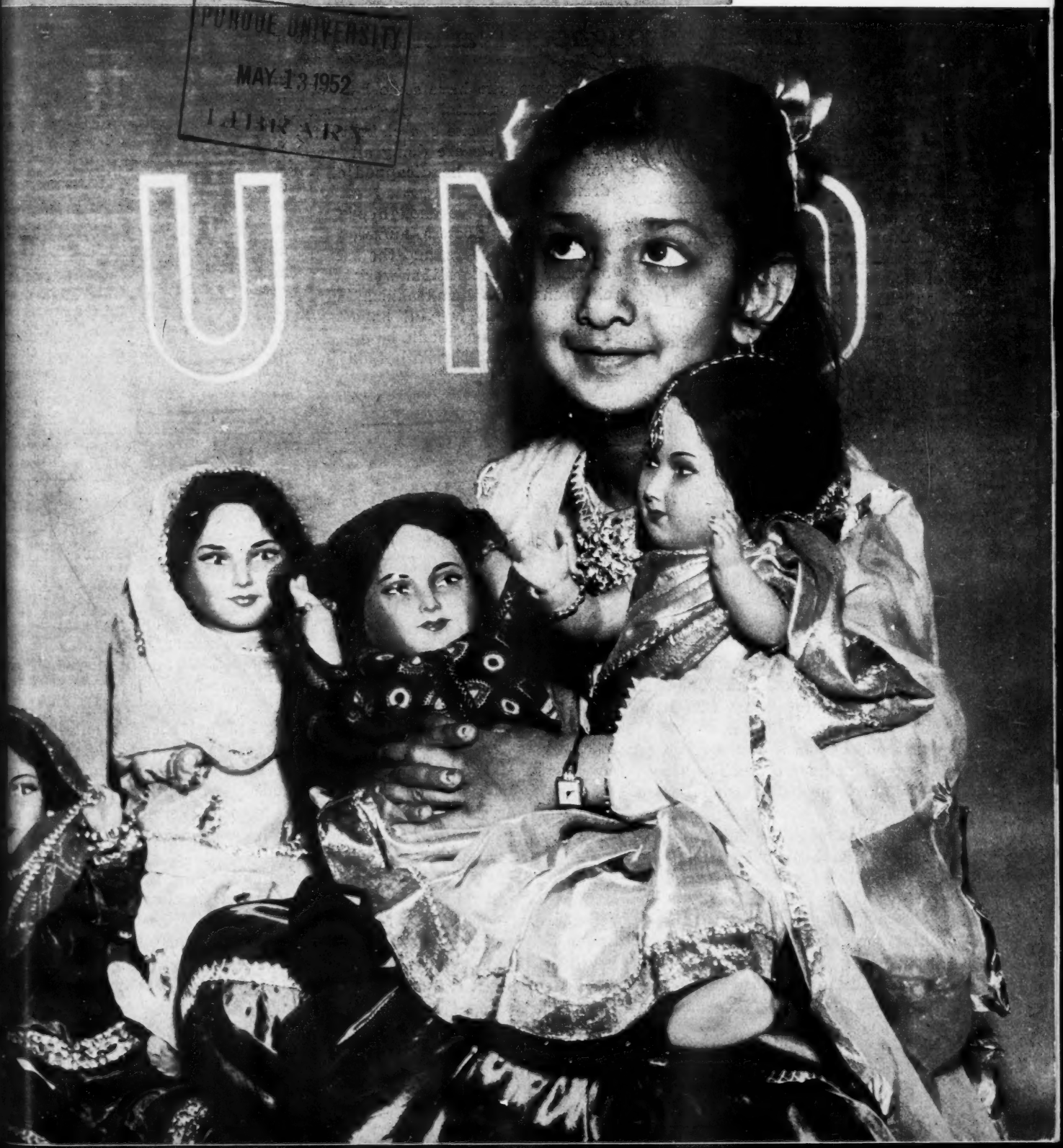
THE CHILD

MAY
1952



Citizens Urged to Make May 1 Friendship Day for Crippled Children Throughout Nation

Martha M. Eliot, M.D.
Chief, Children's Bureau

Child Health Day in 1952 gives us a chance to see how we can make every day of the year friendship day for handicapped children.

Ever since 1928, when both Houses of Congress, by joint resolution, authorized and requested the President to designate May 1 as Child Health Day, citizens, with the guidance and help of State health departments and State crippled children's agencies, have used this day as the starting line for action to build better health for one group of children or another.

One year Child Health Day was the start of a drive to make sure children were immunized against certain contagious diseases. In another year, citizens worked to prevent accidents, which kill more children than any single disease.

This year, the Children's Bureau has proposed that Child Health Day be the day on which we focus our attention on the many thousands of children in our country who have handicapping conditions.

No one has an accurate count of the total number of such children. But there is probably no adult who does not know of some child struggling with a physical, emotional, or mental disability, who could be helped to live a more satisfying and self-sustaining life.

Through our great variety of voluntary organizations, and our small but soundly built public services, we already are transforming the lives of hundreds of thousands of youngsters who have some kind of physical or mental strike against them. But no one can claim that, as a Nation, we are doing all that can be done for handicapped children.

Few of us have enough professional skill as doctors, nurses, psychologists, teachers, and the scores of other professions that work with children to give them technical help.

But certainly we all have one skill we could and should be putting to use for them: The skill of making friends.

For handicapped children want to belong as much as other children do. They want the chance to develop their own initiative, their own friendships and loyalties, their own integrity.

The degree to which any handicapped child can make progress, naturally depends on the disability he has; some crippled children obviously can achieve less than others.

But many more handicapped children could be helped to a happier and more useful life if more of us included more of them in our work and play and in our normal community life.

On Child Health Day 1952 many groups of citizens will be meeting to plan child-health projects. Let's bring the handicapped child out of his isolation and make him one of us.

State Programs Aid Many Thousands of Handicapped Boys and Girls

Arthur J. Lesser, M.D.
Director, Division of Health Services, Children's Bureau

The Nation is making slow but sure progress in its programs for crippled children as more States extend their services to reach children with crippling conditions.

It was not until 1897 that any State passed a law to aid crippled children. Now all States have programs that provide care for at least a limited number of boys and girls under 21 years of age who have a handicap that needs orthopedic or plastic treatment. This means children with hare lip, or cleft palate, or club foot; children with deformed bones; children who have been seriously burned, or otherwise badly hurt in an accident.

About half the States also include in their programs children with rheumatic fever and cardiac conditions. An increasing number are developing services for children with cerebral palsy and those with epilepsy and for children with visual or hearing handicaps.

There is a clear trend toward inclusion of more types of handicapping conditions in State crippled children's programs.

More children now receive care under State crippled children's pro-

grams than in any year since the programs started.

During 1950, approximately 215,000 children received diagnostic or treatment services from doctors, in clinics, hospitals, or convalescent homes, or through office or home visits. This was an increase of 35,000—18 percent—over the number of children who received such care in 1949.

In addition to the care given by physicians, many children also are served by public-health nurses, medical social workers, nutritionists, physical therapists, occupational and speech therapists, and other medical personnel making up the rounded team of a crippled children's program.

State agencies, in offering these programs, receive financial help from the Federal Government through grants administered by the Children's Bureau.

When the Social Security Act was first passed, the amount of Federal grants authorized to help States in their crippled children's programs totaled $2,850,000 annually. In 1939, it was increased to $3,750,000, in 1946 to $7,500,000, and in 1950 to $15,000,000 for each year after 1951.

From the first full year following the original enactment of the Social Security Act until the fiscal year 1951, the full amount of funds authorized by Congress was appropriated each year. In 1951, the total authorized for the first year after the 1950 amendments was $12,000,000, and the amount appropriated was $9,975,000. For 1952 the crippled children's grants total $11,385,500.

The State crippled children's programs are important not only for the care that they provide for children, but also because of the graduate training for professional workers made possible by these funds.

CHILD HEALTH DAY, 1952

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS the Congress, by a joint resolution of May 18, 1928 (45 Stat. 617), authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day; and

WHEREAS the promotion of conditions that make for sound health for the Nation's children should be of vital concern to all Americans; and

WHEREAS it is fitting that we set aside a day each year for special consideration of means for the improvement of the health and well-being of our children:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby designate the first day of May, 1952, as Child Health Day; and I invite all agencies and organizations interested in the well-being of children to unite upon that day in celebrating the past year's gains in the health of children and in considering how programs for the protection and development of the health of the rising generation may be further advanced.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this fifth day of April in the year of our Lord nineteen hundred and fifty-two, and of the Independence of the United States of America the one hundred and seventy-sixth.

Harry Truman

By the President:

Dean Acheson

Secretary of State

FOR THE MENTAL HEALTH OF CHILDREN IN OUR SMALLER COMMUNITIES

TO GET STARTED—

Community action grows from community interest. Here are some ways of bringing mental health to the attention of professional and lay people:

- Speakers and discussions in meetings of professional societies, civic and service clubs, church groups
- Mental health workshops
- Radio scripts
- Plays designed for amateur presentation
- Mental health films

For sources where material and program assistance may be had, get in touch with your State mental health agency.

R. H. Felix, M. D.

APPROXIMATELY three-fourths of American children live in cities and towns under 100,000 population. About a third of these live in rural areas, where we know that specialized health services are less accessible for these children than for the children of big cities. And probably in no health area is this inequality more striking than in mental health services.

This situation is changing. True, we still have a drastic shortage of mental health specialists. Mental health concepts are still relatively unfamiliar, even to some teachers, physicians, nurses, and other professionals who work with children and parents. Nevertheless, in spite of these and other practical obstacles, communities of all sizes and types throughout the country are beginning to build effective mental health programs for their children.

Of the need for such mental health services there is ample evidence. The roots of adult disorders are often found in infancy and childhood experiences. Many types of mental and emotional illnesses first appear or show forewarning signs during the early years of life; prompt attention may stop progress of the disease and restore mental health. Many problems of child development are so common that they are almost "normal" problems; these often can be relieved or eliminated when parents and teachers can obtain adequate guidance. Finally, psychiatrists hold that measures designed to foster a high degree of resistance to mental and emotional difficulties, and to increase mental health, are most effective when applied during childhood.

To give children this kind of help, many communities have established child guidance clinics. These services are staffed by psychiatrists, clinical psychologists, and psychiatric social workers, to provide diagnosis and treatment, or appropriate referral.

Although such clinics are still too few to meet active demands, expansion is limited by (1) a severe shortage of mental health workers and (2) expense. Furthermore, many communities realize that establishment of such a clinic is not the only measure by which a community can help its children toward mental health, nor is it always the most desirable first step in that direction.

DR. ROBERT H. FELIX is Director of the National Institute of Mental Health, Public Health Service, Federal Security Agency.

Dr. Felix was graduated from the Medical School of the University of Colorado, and did graduate work at the Johns Hopkins University. He has been awarded fellowships from the Commonwealth Fund and the Rockefeller Foundation for advanced studies. In the Public Health Service he has been senior medical officer of the U. S. Coast Guard Academy in New London, Conn.; executive officer of the U. S. Public Health Service Hospital for drug addicts in Lexington, Ky.; and clinical director of the Federal Medical Center at Springfield, Mo.

A Pennsylvania judge with a deep and active interest in juvenile mental health problems recently said: "We thought that as soon as we got our mental-health clinic here all our problems would be solved. Now I can see perfectly well how a bad school situation or an ineffective child care service could turn out more problem children on a mass-production basis than any single clinic could ever hope to serve." In many communities, both laymen and professionals are finding that a clinic may be used as a community dump for problems that should and could have been forestalled by better handling a long way back.

The National Institute of Mental Health believes that mental health clinic services are essential to a complete child health program. Through a team approach, the clinic does a job that no other agency in the community can do. The clinic's own team—psychiatrist, psychologist, psychiatric social worker, and nurse—is particularly equipped to meet the needs for specialized services.

Need wider knowledge of mental health

The National Institute of Mental Health also believes that, when a community plans a mental health program for its children, it should not think in terms of clinics alone. Numerous common "subclinical" difficulties often can be handled by parents, teachers, physicians, public health nurses, social workers, and other local people — if these individuals have a basic understanding of mental health concepts. Furthermore, a complete mental health program aims beyond a case-by-case approach. As we see it, the program can help develop many activities within the community that foster healthy child development.

The first step in mental health planning is to find out what kinds of difficulties the children have: Which children have them? Who is affected by them? Who is now dealing with them? How?

School teachers offer us many examples: The children who are intellectually normal, or even superior, yet keep failing to pass; the "bad" boys who continually disrupt the class; the quiet little girls who are apathetic toward both studies and play; the child the whole class is always picking on. Teachers can be aware that these are children who have problems. They may perceive the roots of these problems in inadequate or broken homes; in physical handicaps, or in other situations demanding special handling. In many cases, the causes will be less evident and some will remain obscure even to psychiatric study. In any case, although lacking training and time, a teacher may see clearly that a problem exists and start the wheels rolling toward securing needed help.

The courts also see mental health problems among minors who are brought in for law violations. Even knowing that juvenile offenders need understanding and wise handling rather than punishment, judges often have only two alternatives — probation or commitment of the child to an institution. In a great many cases, neither alternative is a constructive course.

Physicians are often called upon to deal with mental and emotional disorders. Frequently they detect these problems as components of the physical illnesses they treat. Through both undergraduate medical training and postgraduate education, physicians are becoming more familiar with psychiatric methods and mental health concepts. Nevertheless, a certain proportion of their cases will need special help.

Through friendly talk and observation, a psychiatrist gains insight into the child's problems.

Social case workers, too, see how emotional difficulties cause family and individual troubles, particularly how family conditions react upon growing children. The case worker dealing with children is in an especially strategic position to detect difficulties and help in their solution. Nurses and physicians in well-baby clinics and school health services have excellent opportunities to notice the early appearance of mental health problems. Clergymen are very frequently consulted on child-behavior problems, and, according to a recent National Institute of

Mental Health survey in one city, would be consulted in preference to a physician by many who have child behavior or marital problems. Lawyers find that many cases hinge upon mental and emotional factors. In short, members of every profession that deals with people will inevitably run into mental health problems, deal with them in some fashion, and, at some point, will probably need specialized help.

How can a smaller community get this help for its children?

As the program grows

A certain number of children present problems that call for intensive diagnostic study. The smaller community in some cases can make arrangements to secure clinic services from a traveling clinic team, either from a nearby university or the State mental health agency. In some instances the community can arrange to send children to a nearby guidance clinic upon referral by a physician or by an agency. There are advantages in having one community agency responsible for clinic referrals. A central file can be maintained in which individual records are kept on each child, accessible to all agencies that may be involved. Special personnel — a psychiatric social worker or a public health nurse — might help the referring physician or agency by working up the background data for the clinic and acting as liaison in the follow-up. Furthermore, such a regular connection with the clinic helps to develop a basis for further cooperation as the community program grows.

Social case worker a key person

The work of a psychiatric clinic does not end with diagnosis. Some children will need the kind of treatment that only the clinic can give; some will even need institutional treatment. But most cases, it is found, can be greatly helped by parents, teachers, and others if the clinic staff can help them comprehend the child's problems and needs. The social case worker in the community becomes a vital link between the clinic and community, helping to interpret clinic findings and recommendations, consulting with the clinic on new problems that may arise, and obtaining maximum assistance for the child from community resources.

Let us see what might happen to a 10-year-old we'll call Billy. His teacher reports to the principal that she cannot control him in class, that he disrupts the entire fifth grade. The mother, harassed and overtired from coping with four active children, ranging from Billy down to a 6-month-old girl, says that she cannot do anything with Billy at home, to say nothing of making him behave at school. Billy, she admits, is a terrible worry to her, refuses to eat properly, and still wets his bed.

As a result of the public health nurse's consultations with the teacher, Billy's parents, and the family physician it is decided that Billy's problems are too serious to be ignored and that the community has no adequate services to handle them. Through the county health department, arrangements are made for Billy and his mother to go to the visiting child guidance clinic which makes this town part of its circuit.

Billy's mother feels that she can understand him better after these clinic visits. She begins to give her whole family more emotional security, because the tension that has been affecting all of them begins to let up. The public health nurse, who has been consulting with the clinic throughout, keeps in touch with her and also talks with Billy's teacher, and the family doctor. Billy is getting help from all the people who are most important in his life. A community team is in action.

Happy impressions and associations in early years lay foundations for sound mental health.

Relatively simple as this procedure may be, it obviously cannot be established overnight. Billy's teacher saw and recognized a problem. Furthermore, because the community had included mental health in its public program, she had somewhere to take this problem. Such a service does not necessarily need to be located in the health agency. In other communities, the mental-health service for children might be centered in the schools or in an interagency unit. At any rate, this county had a specific person responsible for mental health services, someone who could consult with the

people who knew Billy, decide whether Billy needed outside help, refer him to a suitable clinic, and follow through while Billy's problems were being ironed out.

Help for Billy also depended on people with some training and understanding of mental health concepts. Although the teacher could not help Billy unaided, she knew that he wasn't a "bad boy" and that he needed help. The public health nurse had needed considerably more training and experience to carry out her part. Some of this came from her regular training in public health nursing. More may have come from participation in mental health institutes and workshops. Perhaps she had taken courses at the State university or had actually trained at a child guidance clinic. Also, the mental health program had to have adequate support. Even if the nurse maintained this mental health service only as part of her job, this portion of her time had to be financed by public, community chest, or other funds. The community provided office space in which the clinic could hold its interviews and conferences.

Finally and basically, success depended on cooperation of all citizens, both professional and nonprofessional. If the teacher or any other professional person had been reluctant to get psychiatric aid for Billy, a noncooperative attitude might negate the work of many others. If Billy's mother had not been willing to take her boy to the clinic, little could have been done. Evidently the mental health program of the health department had the confidence of the community because there was adequate understanding of its purposes and techniques.

The clinical psychologist, through a series of tests, learns much about the child's personality.

Only a few of the children with problems require clinic help. However, most children have problems one time or another. How can a community help all its children over the mental and emotional humps of growing up? Can it reduce the need for clinic services by dealing with these problems promptly and constructively?

Staff conferences, in schools, in health and welfare departments, are one way to give people who work with children an opportunity to talk about situations as they arise, to get other people's views, and to work out answers to some of those difficult problems.

The case conference idea as a technique for in-service teacher training has been developed in several places. The University of Michigan and the Mott Foundation have developed a program for training teachers drawn from various public schools in the city of Flint. Introductory sessions give material on child development with emphasis on how the impact of public school experience differs for different children. Teachers also learn specific techniques in counseling, interviewing, and gathering family data, as well as becoming acquainted with community resources. The courses are conducted by psychiatrists, psychologists, and psychiatric social workers, one of the latter serving as course coordinator. Cases discussed are deliberately selected to include some children who do not present problems, this study of notably well-adjusted children serving to highlight facts about mental health which otherwise might not be brought out.

Early study of children helps

In Des Moines, Iowa, a similar project works on a school-by-school basis, bringing teachers to study and work out cooperatively the problems of children they all know.

A community in South Carolina recognizes that teachers need not only training but also time to study the children. During the first month of school, half of the first-grade teacher's time is spent in studying the new pupils, visiting their homes, and carefully recording what she learns about their development and background. This is the start of a cumulative record which is maintained and kept up-to-date as the child goes through school. Each year, part of the teacher's time is allotted to this continuing study, which proves its usefulness in dealing with practical problems that arise in the course of the child's development.

These and other ideas can be applied in other communities, large and small. Basically, their pur-

pose is to help teachers understand the children in their classrooms and become more aware of their problems and of how the educational-social experience of school life affects them. Through this increased understanding, the teachers not only can give more help to the children but also find more satisfaction in their work. Modifications of these projects, of course, are applicable to health and welfare agencies, as well as juvenile courts and law enforcement agencies, scout groups, and other youth organizations. Obviously, no blueprint can be drawn up to give step-by-step procedures in establishing such projects. Like all problems in community organization and action, the mental health program must be tailored to fit local needs and resources.

Clearly one of the first needs is to find people in the community who are interested in helping children with problems. If these people have training and experience in mental health work, so much the better. However, many types of background and experience lead to a concern and responsibility for the welfare of children.

Community workshop a useful tool

For an introduction to the methods and concepts of mental health work, institutes and workshops have proved extremely useful. In Pennsylvania, for example, the idea of mental health workshops has spread rapidly. Usually they are sponsored by local people—schools, parents, and civic groups—and made possible by the State bureau of mental health. A wide cross-section of Pennsylvania citizens and communities are obtaining a broadened vision of what a mental health program can do. Results may already be seen in terms of real action programs in large and small towns. Such workshops last for 1 or 2 days, consisting of talks by psychiatrists, psychologists, and other professionals, plus group discussions in which these experts help the local people work over mental health problems as they affect the community. Mental health institutes usually last from two to three weeks, giving the opportunity for more intensive study — actually a sort of introductory course in mental health.

Teamwork in a California community

A mental health study group has had deep and far-reaching effects on one community in Alameda, Calif. Since 1948 a group of agency workers have been meeting monthly, using the case-conference approach to point up community problems and develop interagency worker relationships. Participants include people from schools, health department, vocational rehabilitation office, juvenile court, welfare agencies, Veterans Administration, and county medical society social service department. Interagency teamwork has developed tremendously, as has development of such services as those for children with cerebral palsy and for retarded children, services given at a speech clinic, and in-service teacher training. Emphasis is on early recognition and referral of children with problems.

As a community program develops, it will require more trained people. Enthusiasm and initiative are needed — but so are experience and knowledge. For workshops and institutes, a community may bring in visiting consultants. For day-to-day program operation, a community must develop its own supply of trained personnel. Social workers will be needed who can serve as liaison between the community and the out-of-town psychiatrict consultants and clinics. They will be needed to coordinate in-service training and discussion groups. A demand may arise for teachers who can teach remedial classes, work with physically handicapped children, and provide other special services. To get these trained people, community agencies may encourage their staff members to take special courses, while an active and growing program will attract the graduates of university and other mental health training courses.

At some point, the community will have to decide whether it intends to build up complete mental health services or whether it will never be able to justify support of full clinic services. A community that decides to aim for a clinic should make an effort to obtain many services on a referral basis until they can be provided by specialists in the community. A smaller community, which frankly will never be able to maintain a clinic, must make more strenuous efforts to train its present personnel and to recruit with an eye to interests and skills for mental health work, or must work out some method whereby children can be transported to a center where services are available.

Most communities will need outside assistance for the most effective development of a mental health program. The National Mental Health Act was passed in 1946, providing grants-in-aid for State mental health work, and today all States have active programs. Many of the State mental health agencies are prepared to give aid to communities in program planning, through assignment of professional personnel for workshops and other training activities, and through financial assistance for projects.

Help comes from many sources

Another place to find assistance is in the universities, particularly those with strong psychiatric training programs. The medical schools, the schools of social work, education, and public health, and the graduate psychology departments all can help. The University of Colorado shows how such a center can help small mental health programs grow. Its traveling psychiatric clinic tours a large circuit of towns around Denver. Psychiatric social workers, trained at the university with the clinic staff, are located in each of these stop-off points to work up the cases and serve as liaison between clinic and community. As the local programs grow, with the aid of consultants from the

(Continued on page 142)

PENNSYLVANIA SPEAKS OUT FOR CHILDREN

Twelve communities focus attention on child-welfare needs

MANUEL KAUFMAN

SOMETHING NEW and exciting is happening in Pennsylvania. Long-distance wires are humming; each mail brings new inquiries; and before long people may even be talking over the back fence about what it means in their community.

What is it?

Briefly this—the Governor's Committee on Children and Youth will conduct open hearings on the unmet needs of dependent and neglected children.

To focus attention on child-care services

Scheduled during May in 12 strategically located Pennsylvania communities, the hearings will provide an opportunity for interested citizens, as well as civic organizations, to make themselves heard about local conditions.

Why have we selected the unmet needs of dependent and neglected children for special consideration this year? Because reports from county committees to the State committee before the White House Conference indicated that many Pennsylvanians are deeply concerned about lack of services for these children.

We are hopeful that the outcome will provide a measure of public opinion which cannot be ignored. Although leaders in the field of child welfare have long recognized the need, the time has come to stimulate public action. If we are to solve this problem, citizen interest is a "must."

The open hearings will, we hope, focus attention on our child-care services and provoke an expression of public feeling about them that will be a guide to public action, including legislative change, in any area of child welfare. It is possible that we also may discover what changes would be supported and whence that support might come.

What does the public want?

If a large and representative attendance is stimulated in many communities and if there seems to be sufficient concern about specific needs, with some indication of how the public would like to see them met, the Governor's committee can arrange for legislation to be drafted.

It is not the purpose of the committee to promote any specific pro-

(Continued on page 142)

MANUEL KAUFMAN is chairman of the subcommittee of the Governor of Pennsylvania's Committee on Children and Youth, which proposed the holding of open hearings on the unmet needs of dependent and neglected children. Formerly Child Welfare Consultant to the Health and Welfare Council of Philadelphia and vicinity, Mr. Kaufman was recently appointed Deputy Commissioner of Welfare for the City of Philadelphia.

ARE CHILDREN OF MIGRANTS THIRD-CLASS CITIZENS?

IN THE MIDST of our generally progressive economy, there exist today thousands of children to whom poverty, privation, hard work, ignorance, and disease make up the normal pattern of everyday life and who cannot look forward with any certainty to a better lot in adulthood unless they receive help soon. These are the children of migrant farm workers in some sections of our country.

The evils associated with the use of migratory labor and their effect on the children of migrants are discussed in vivid detail in a study published recently by the National Child Labor Committee. The report, Migrant Farm Labor in Colorado, a study of migratory families, includes a number of specific recommendations designed to improve migrant living in Colorado. The committee has also published a dramatically illustrated pamphlet, Colorado Tale, presenting in abbreviated form the major findings of the study.

The report was based on a study of 262 families, with 1,513 members. These families comprised a random sample estimated to be about one-tenth of all the migrant families in the State.

Problems of migratory labor have for many years concerned the National Child Labor Committee, Federal and State agencies, and other groups interested in social welfare. The committee conducted this study in Colorado between July and October 1950 at the request of the then Governor, who had created a Survey Committee on Migrant Labor to study conditions in the State and make recommendations to the legislature.

Facts reported in the study will probably be shocking to the majority of Americans who smoke their cigarettes, wear cotton clothing, and stir sugar in their coffee, completely unaware that some migratory laborer, perhaps a child living and working under miserable conditions, has probably harvested the crop that made each of these products possible.

Few of the places where migrant families stop have day nurseries or foster-family homes where children are cared for during the day time. Many a child like this one spends the day in the field where the mother is working. This picture was taken near Brush, Colorado.

What are families of migrant farm workers like? The survey found that these families were large, averaging almost six members; and it found that children of 14 and younger made up close to half of all persons in the families studied. Although the families interviewed came from 11 States, nearly half were from Texas, and practically all were Spanish American. Approximately half the group spoke only Spanish. The great majority of the parents had had very little schooling, and nearly a third were illiterate.

Why they follow the crops

Economic distress and inadequate job opportunities at home were the most usual reasons for migration by these families. Although only primary reasons for migration were sought and tabulated, many household heads mentioned "wetbacks" (illegal entrants from Mexico) as a contributing cause of their migration. Many of the Colorado migrants said that labor contractors help get wetbacks into Texas; the wetbacks force down wages at home so that "we have to move up here."

The families' annual cash income from seasonal farm work and all other sources averaged $1,424 for the year 1949. Perquisites such as housing, fuel, and water received by some workers would increase this figure somewhat, though the "value" could not be rated very high, considering the condition of much of the housing. Since the families averaged 5.7 persons, average yearly income among Colorado migrant families was about $250 per person.

Housing conditions for migratory workers were generally very bad; the average living quarters were badly overcrowded, dirty, insanitary. Over 90 percent of the families had no means of refrigeration; only one-third could be sure their water supply was safe. Most families used

pit toilets, of which less than one-fourth would have passed elementary health inspection. Sixty percent of the families had no bathing facilities.

A detailed study was made of the diet of these migrant families; and it was found that cheap, starchy foods were their usual fare. Meat was rarely seen; milk, fruit, and vegetables were scarce. Butter and margarine were almost entirely missing. Generally, the amount of food was insufficient.

Migrants had very little health care; the infant mortality rate in migrant families was nearly twice as high as that for the State of Colorado as a whole.

Centers where children were cared for while their mothers worked were almost nonexistent, although more than 100 mothers with children under 10 worked full-time or part-time. In two farm-labor camps the Home Missions Council operated a program of supervised activities for children. But most often children under 10 were taken to the fields and left in sheltered areas —as the report says, "... 'sheltered' in some cases being the shaded side of an onion sack." Others were cared for by older children, elderly people, neighbors, or relatives. Some were left at home unattended.

Little progress in schooling

The findings of the study in regard to child labor and education make up a disturbing aspect of the whole migratory-labor picture. Data on child labor and school attendance were not easy to get; in two areas, according to the study, "Regardless of size, birth date, or other factors, children at work who were asked their ages tended consistently to be '16 years old my last birthday.' "

Most of the children 7 to 16 years of age worked on crops. The work periods of the majority of children were spread over 7 months; leaving only 5 for school. The average working day was between 8 and 9 hours; but, according to the study, almost one-third of the children who worked, worked from 10 to 12 hours a day.

As would be expected under the circumstances, retardation in schooling was widespread. When data for 372 children 7 through 16 years of age were analyzed by age and last grade completed, it was found that none of them, regardless of age, had gone beyond the fifth grade. The great majority of children 10 through 16 had not gone farther than the first or second grade. Only 49 children of the total 372 had completed the grades normal for their age.

Lack opportunities to learn

"This does not mean," the study points out, "that these migrant children are less able to learn than other American children because of ethnic or geographic origin which makes them 'different,' as the prejudiced frequently claim. It simply means that no children can make normal educational progress unless they can attend school regularly and are given the opportunity, if they are second-generation Americans, to learn the language, the customs, and the culture of the country of which they are citizens."

When parents were asked why their children were not in school the usual replies were: They "had to stay home to care for younger children"; their "earnings were needed"; they "didn't speak English"; or they would "start school back home."

Children come home from school crying

After the confidence of some of these parents had been gained, however, other reasons for nonattendance were uncovered. The following statement, according to the report, was typical: "Our children were sent to school. If the schools were not too crowded or if the children were not sent home for other reasons, they would come home crying and begging us not to send them back. Why? Because the other children made them feel that they are different. Their clothes are not so clean. Sometimes the shoes are too big or worn out, and the other children laugh at them. . . . Everybody laughs at them because they speak so funny. Then because they cannot understand easily, they are thought to be stupid. . . . Our children do not play the Anglo games well. They stand by the sides and are called names and made to feel ashamed. . . . Juan is the biggest boy in his class. Even the teacher thinks he is dumb. But, believe me, he has never had a chance to go

Space between tents is the "playground" of these youngsters, who are the children of migratory agricultural laborers. This picture was taken at a camp near Fort Collins, Colo.

to school. So you see, we keep our children home—not to make them work, but because it is not so bad as seeing them come home crying."

Truant officers who were questioned described the difficulties of enforcing school attendance among migrant children and pointed out that enforcement would be in opposition to the wishes of the community, their own friends, and the workers themselves. The truant officers felt that it would be better if a program were set up to educate the parents and the community in the value of school attendance before enforcement is begun.

School superintendents were aware of the need for stronger compulsory-attendance laws and more attendance officers, but beyond this they also saw the problem of providing enough space and enough teachers for a seasonal overload and the problem of how to make short periods of attendance profitable for children who are retarded and constantly on the move.

Specific measures recommended

The study made by the National Child Labor Committee is broad in its scope and goes beyond problems related directly to the children of migrants. Employment and income problems; questions of recruitment, placement, and transportation; discussion of social participation and community attitudes are included in the report.

Recommendations that the committee drew up are designed as specific measures to unravel some of the problems of migratory labor in Colorado. The committee's first recommendation is that a State commission on migrant labor should be established, composed of representatives of all State agencies concerned with seasonal agricultural labor and of representatives of the general public. The commission would coordinate and give direction to the programs of agencies dealing with the problem. It would direct research, make recommendations for legislation, and assist local groups to develop programs that would interpret the workers to the community and the community to the workers. It would promote regional agreements with other States.

A series of detailed recommendations are made regarding the health of the migrant families, their housing, the education of the children, child labor, recruitment, wages and income, and public-assistance programs.

The need for a State-wide health program for agricultural migrants in Colorado is as real as the need for their occupational services in the State, the report says, offering recommendations that the committee considers essential not only for the welfare of the migrant workers and their families, but for the safety of the community at large.

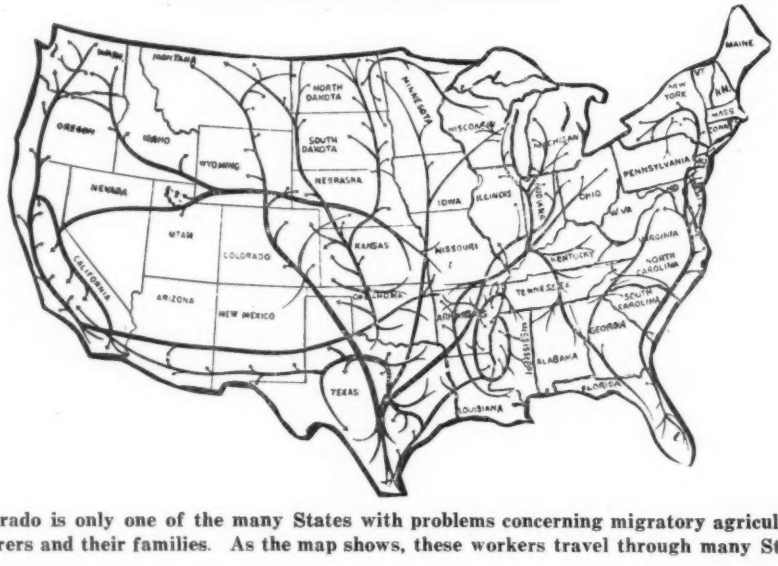
Noting that seasonal agricultural workers are a highly mobile group and that communicable disease easily spreads from one community to another, the committee urges a number of health measures aimed at preventing epidemics. Special detection and treatment clinics and health services should be made available to migrant workers and their families, the report says. Bilingual, and preferably well-qualified, Spanish-American personnel should be employed for these services, the committee recommends. Clinic services should be available after working hours.

Mobile clinics and camp clinics are needed, according to the recommendations, and these should include, among others, clinics for children, and clinics for prenatal and postnatal care. Among the other services recommended are public-health nursing, mental-hygiene consultation services, and popular health-education activities.

The possibility of additional assistance through the Federal grants-in-aid programs administered by the Public Health Service and the Children's Bureau, both of the Federal Security Agency, should be investigated, the report says, with a view to increasing State personnel and facilities available for health, sanitation, and inspection programs for migrant workers.

For the improvement of education among migrants, the committee recommends several specific methods for increasing efforts to obtain school attendance, increasing financial assistance to schools in areas with migrant children, improving educational facilities for such children, gaining acceptance of them in the schools, and extension of adult education.

TRAVEL PATTERNS
Migratory Agricultural Workers



Colorado is only one of the many States with problems concerning migratory agricultural laborers and their families. As the map shows, these workers travel through many States.

Several revisions in the Colorado child-labor law are recommended by the National Child Labor Committee. The present provision establishing a minimum age of 14 for most occupations should be amended, the committee feels, to include, specifically, commercial agriculture. The committee recommends also that the law be amended so that it will be illegal to employ children under 16 in any occupation, including farm work, during the hours the schools are in session. Work permits, based on proof of age and a certificate of physical fitness, should be required for the employment of children of 14 and 15 years in commercial agriculture outside of school hours, according to the committee's recommendations.

Explaining its recommendations the committee says:

"The use of migratory farm labor in Colorado, as elsewhere, creates difficult problems for the migrant workers, for the family members who accompany them, for the growers who rely on their labor, and for the communities where they temporarily reside.

"Poorly housed, poorly paid, poorly educated, poorly protected in legal ways, the migrant lives and toils under shockingly substandard conditions. For him and the members of his family, the problems of migrant living are problems of human misery.

"The grower—the employer of migrant labor—has his problems too, different in nature but equally real," continues the report. "He has a highly perishable crop, which, under the dictates of nature, must be handled and harvested during a certain, short period of time, or be lost. He cannot obtain suffiicient labor for his needs from within the local community and must rely on the uncertain stream of laborers from outside the area.

"As an employer, the grower would prefer, if he could, to limit his responsibilities to these temporary workers to the payment of a fair day's wage for a fair day's work, and not concern himself with such matters as housing, health, the care and schooling of children, which are problems not ordinarily faced by an employer in his relation with his workers.

"But," says the report, "if he is at all concerned with building a more stable labor force upon whom he can rely season after season, if he is concerned about productive efficiency, he cannot afford to ignore these problems of his workers, because a dissatisfied worker is a poor and unreliable worker and one whose anxieties and discontent inevitably lower his dependability and productivity.

Communities are under moral obligation

"The communities to which migrants come have their own difficulties also—difficulties multiplied by the needs of tens of thousand of temporary residents for housing, health, welfare, and educational services which already may be inadequate even for the resident population.

"Nevertheless," the report says, "each community where migrants live and work has an obligation—moral if not legal—to meet the basic needs of their temporary residents, and it is indefensible to set them apart as second-class citizens for whom community services should not be made available.

"The migrants are productive workers, vitally necessary to the economy of the community, and by their labor they contribute to its wealth and prosperity. Each community which they enrich has the corresponding obligation not to deny these temporary residents the services and facilities and protective legislation available to others," says the committee.

"In considering these problems, the report goes on, "the fact must be faced that the need for migrant labor in Colorado will remain for a long time, although it may be reduced somewhat by basic changes in methods of agricultural production, such as fuller development of mechanization, or by slow changes in the agricultural economy or in the population patterns of the State."

The recommendations of the committee do not outline a Federal program. "It is assumed," the report says, "that the National Government will increasingly recognize its responsibility in dealing with this problem, which has many inter-State aspects, and it is also assumed that migrant workers should be given the protection offered to other workers under our social-security system and our Federal labor legislation. But the chief hope for immediate improvement of existing conditions," says the report, "lies in a planned and coordinated effort by State and local agencies, cooperating with Federal agencies as a national program is developed. These recommendations suggest action that can be carried out through existing agencies of the State of Colorado, through regional agreements with other States from which migrant workers are recruited, and through action in the communities where migrant workers are used."

"None of these recommendations is theoretical or impossible, the committee maintains. Many have been tested and proven practicable in other areas of the Nation with migrant problems similar to Colorado's.

What of the cost?

"Recommendations are one thing; their realization is quite another," the report goes on to say. "Putting these recommendations into practice will require more than will and wisdom. It will require also an expenditure of funds. The National Child Labor Committee has no wish to shy away from that difficulty by refusing to mention it," says the report. "But the costs are neither extravagant nor great, by any measure. They do not contemplate luxury levels of living—only the barest level necessary for minimum standards of health and decency. The costs involved in the recommended programs," says the committee, "are in reality only a modest capital investment in people who are necessary to Colorado's prosperity, and will assuredly yield satisfying dividends in human happiness and increased productivity."

MENTAL HEALTH

(Continued from page 136)

university, they are able to recruit staff from among the graduates of the university schools.

The National Association for Mental Health and its affiliated mental hygiene societies can help with materials for both professional and lay education, as well as community organization. It is concerned with public information and fund raising. In most counties there are local groups and individuals with valuable experience in community education and service — the health council, the tuberculosis association, the cancer society, the women's club and civic groups, the county agents and home demonstration agents. Parent-teacher groups, of course, would have a prime interest in a mental health program for children and would be among the first to participate.

It is still extremely difficult for the smaller community to obtain help for its children with problems. The dearth of professional personnel plus the geographical distribution of psychiatric services present serious obstacles. Nevertheless, as this article suggests, new ways are being developed to bring psychiatric services in reach of outlying areas and, by bridging the gap from the other end, to help the people of these communities organize and educate themselves to do a large part of the job. Generally speaking, the small community program seems to be highly effective when, like the Alameda program, its basis is interagency and, like the programs in the Colorado towns, it maintains close affiliation with a university center. Developed with care and under competent professional guidance, such programs can conform to sound professional standards. Built up, as they must be, through intense local interest and efforts, they will have strong support and be based firmly upon real community needs.

Reprints in about 6 weeks from the National Institute of Mental Health, Bethesda 14, Md.

PENNSYLVANIA

(Continued from page 137)

posals through these hearings. In a sense, they will be public-opinion polls. It is our purpose to find out whether the people of our State believe that local child-care resources are adequate in quality and quantity, what needs they recognize, how disturbed they are about those needs, and what suggestions they have about how the needs might be met.

Everybody welcome

We hope to gain the attendance of representatives of labor, business, veterans' organizations, civic groups, schools, and welfare agencies. Our aim is to draw to these hearings the general public, together with the lay and professional people in the field who have been trying for more than 20 years to get essential changes in Pennsylvania's machinery for child care.

Testimony will be heard on the adequacy of services provided to the following groups:

Children who must be cared for in foster homes or institutions, most of whom are maintained at public expense.

Children living in their own homes who are neglected, mistreated or exploited by their parents or guardians, or who are in danger of becoming delinquent.

Unmarried mothers who need help in obtaining proper care for themselves and in making plans for their babies.

Children whose parents wish to place them for adoption.

Children with mental and physical handicaps whose parents need help in arranging for special facilities.

Children with problems of personality or behavior that seriously interfere with their getting along in school, at home, or in the community.

What care are the children getting?

We want to obtain a composite picture of child-welfare needs. We are not attempting to gather statistics, but rather to make clear what experience has revealed at the grass roots of Pennsylvania about the quantity and quality of child-care services.

Many fields represented

The hearings will be confined to one subject—the unmet needs of dependent and neglected children and suggestions for meeting these needs. Statements will be limited to 10 minutes each, so that we may learn the opinions of many people. We request that the statements be written and that two copies be presented to the hearing panel. It is intended that the hearings will have a formal air because of the seriousness of the problem. Members of the Governor's committee will serve on the hearing panels; and it is significant that committee members who were chosen because of their interest in other fields, such as health, recreation, and education, have welcomed an opportunity to participate in the hearings.

Citizens can speak out

The Governor's committee has no magic flute with which to draw people to these hearings and to insure that they will make statements based on facts. The committee can and will invite every organization interested in child care to make a statement. We are arranging with the officers of State organizations to urge local members to attend and make statements.

Whether attendance is good and whether the statements are based on accurate information will depend on how much interest we are able to create. The Governor's committee will issue invitations, provide the setting, and take the testimony. How many speak, and how pertinent is their testimony, is up to the public.

In Pennsylvania these open hearings will provide a unique opportunity for every citizen who cares to speak out for children.

• IN THE NEWS

An advisory committee on delinquent and socially maladjusted children and young people, serving the International Union for Child Welfare, will meet at Rome, Italy, some time between September 28 and October 4, 1952. The committee desires to invite qualified United States workers to attend this meeting, the subject of which will be "The Choice of Treatment." Juvenile-court judges, psychologists, educators, psychiatrists, social workers, heads of training institutions for delinquents—these and others will be welcome. Write to Mrs. J. M. Small, Deputy Secretary General, 16, Rue Du Mount Blanc, Geneva, Switzerland.

Summer Courses

Louisiana State University. School of Social Welfare. Baton Rouge 3.

Some of the short courses. Workshop: Children and public-welfare agencies (June 30 to July 18). Institute: Public relations of public-welfare agencies (July 18 to 19).

Some of the 9-week courses (June 6 to August 9). Social services for children; children in foster care; and visiting-teacher work.

Nursery Training School of Boston, Boston 15, Mass. For experienced nursery-school or kindergarten teachers: A special course in teaching young children who are crippled, blind, or deafened. Regular courses in early childhood education for students who have done some work in this field. Also a try-out course for high-school students and others who are considering entering the field of early childhood education (June 30 to August 8).

University of Michigan. School of Social Work. Ann Arbor.

Besides the regular courses, and a new program of 2-week institutes, a workshop in human behavior will be provided under the auspices of the School of Education, the Department of Sociology, the Department of Psychology, and the School of Social Work. The workshop is an integral part of the University of Michigan Fresh Air Camp, near Pinckney, Mich., a group-therapy project for 240 maladjusted boys sent by some 30 cooperating social agencies. Students spend half their time in supervised counseling activities and half in related courses (June 23 to August 16).

Washington University. The George Warren Brown School of Social Work. St. Louis 5, Mo.

Social case work; Social planning in an urban area; Disease and its social component; Methods of social research. First term (June 16 to July 25).

Psychiatric aspects of human behavior. Second term (July 28 to August 29).

• FOR YOUR BOOKSHELF

MOTION PICTURES ON CHILD LIFE; a list of 16-mm. films. Compiled by Inez D. Lohr. Federal Security Agency, Social Security Administration, Children's Bureau. Washington, 1952. Processed. 61 pp. 40 cents. Superintendent of Documents, Government Printing Office, Washington 25, D. C.

This list of films relating to all aspects of childhood was prepared by the Children's Bureau to answer hundreds of requests for such information from the general public and professional people who work with children. It is the first such list that the Bureau has prepared.

The list includes more than 450 films on social. medical, mental, and developmental aspects of child life.

Each film is briefly described, but no attempt has been made to evaluate the individual films.

THE ADOPTED FAMILY: Book I, YOU AND YOUR CHILD: a guide for adoptive parents. 64pp. Book II, THE FAMILY THAT GREW. [A story book for the adopted child.] 20 pp. By Florence Rondell and Ruth Michaels. Crown Publishers, Inc., 419 Fourth Avenue, New York 16, N. Y. 1951. Two volumes, boxed, $2.50.

So far as I know, this is the first time an effort has been made in book form to give advice to adoptive parents about situations that they must face.

The authors omit some things that trouble adoptive parents. but what they do tell is extremely helpful and reassuring. They discuss establishment of the new family, and emphasize that the adoptive parents are the child's **real parents.**

Suggested ways of announcing the arrival of the child, what not to tell interested relatives and neighbors, explaining adoption to the child, answering his questions about his biological parents, and the adolescence of the adopted child are some of the subjects considered in the book. It also contains a list of recommended reading for parents.

When the authors discuss telling the child about his adoption they suggest that the parents read aloud to him "The Family That Grew," from the time he is 5 years old, to help him understand how he and his parents came to be a family. They suggest that the small child will enjoy looking at the pictures, and that later he can read the book himself. From personal experience, however, I believe that the child can and often should be given the word "adoption" to add to his vocabulary before he reaches the age of 5. A little child is as likely to enjoy a story about adoption as any other story.

"The Family That Grew" begins with the birth of the child. It explains to him that the parents who started him could not keep him and therefore went to a "special person whose job it is to know about children," asking her to find the right father and mother for him to grow up with. It says, "Choosing a child is called adopting a child," and stresses how glad Daddy and Mommy are that they adopted this particular child.

I. Evelyn Smith

Illustrations:

Our cover picture, published through the courtesy of the United Nations International Children's Emergency Fund, shows 5-year-old Anjum Chhatari, daughter of the First Secretary of the Pakistan Delegation to the United Nations. Anjum is holding some dolls that were presented by Pakistanian children to the UN representative in Pakistan in gratitude for help given by UNICEF in building up and extending its child-health and child-welfare services and in attacking malaria, tuberculosis, and other diseases that attack large numbers of children.

Pages 133 and 135, U. S. Public Health Service, Federal Security Agency.

Page 134, U. S. Army photograph.

Page 137, Edward Steichen.

Pages 138 and 139, courtesy of the National Child Labor Committee.

Page 140, Extension Service, U. S. Department of Agriculture.

THE CHILD

VOL. 16 NO. 9

MAY 1952

In This Issue

Child Health Day—May 1, 1952 ..... **130**

For the Mental Health of Children in Our Smaller Communities **132**
R. H. Felix, M. D.

Pennsylvania Speaks Out for Children **137**
Manuel Kaufman

Are Children of Migrants Third-Class Citizens? **138**

Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran **Art Editor, Philip Bonn**

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Martha M. Eliot, M.D., Chief

Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C.

For others the subscription price is $1.25 a year. On all orders of 100 or more sent to one address there is a discount of 25 percent. Send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies 15 cents each.

Foreign postage—25 cents additional—must be paid on all subscriptions to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

CALENDAR

June 1-5. National Conference of Jewish Communal Service. Fifty-third annual meeting. Chicago, Ill.

June 2-4. President's Conference on Industrial Safety. Washington, D. C.

June 7-8. American Diabetes Association. Twelfth annual meeting. Chicago, Ill.

June 8 (opening date). International Labor Conference. Thirty-fifth session. Geneva, Switzerland.

June 9-13. American Medical Association. One hundred and first annual session. Chicago, Ill.

June 14. Canadian Welfare Council. Thirty-second annual meeting. Quebec, Canada.

June 16-20. Biennial Nursing Convention. American Nurses' Association, National League of Nursing Education, and National Organization for Public Health Nursing. Seventeenth meeting. Atlantic City, N. J.

June 22-25. National Congress of Colored Parents and Teachers. Twenty-sixth annual convention. Institute, W. Va.

June 23-25. American National Red Cross. Annual convention. Cleveland, Ohio.

June 23-28. American Physical Therapy Association. Twenty-ninth annual meeting. Philadelphia, Pa.

June 24-27. American Home Economics Association. Forty-third annual meeting. Atlantic City, N. J.

June 28. American Hearing Society. Thirty-third annual meeting. Chicago, Ill.

June 29-July 4. National Education Association. Ninetieth annual meeting. Detroit, Mich.

To Our Readers—

We welcome comments and suggestions about **The Child.**

☆ U. S. GOVERNMENT PRINTING OFFICE: 1952-952609